STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 12/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 12/13/16 through 12/15/16. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term requirements. The Life Safety Code survey/report will follow. The census in this 108 certified bed facility was 90 at the time of survey. The survey sample consisted of 16 current resident reviews (Residents #1 through #16) and 6 closed record reviews (Residents #17 through #22).	F 000		
F 167 SS=C	RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE CFR(s): 483.10(g)(10)(i)(11) (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and	F 167		1/13/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/29/2016

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F 167	Continued From page 1 (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility staff failed to post the past three years of survey results conducted by Federal or State surveyors. The findings included: During the General Observations of the facility on 12/14/16 through 12/15/16 the facility staff failed to have a posting and make the results of the past three years survey results readily accessible to residents and the public. A review of the survey results book identified by the facility, contained one year of survey results. There were no notice of where the most recent past three years of the Federal survey results could be located for examination. During an interview on 12/15/16 at 12:25 A.M. with the Administrator, He stated he was not up on the new requirements. The Administrator searched for about 25 minutes to produce three years of back survey results. When told the survey results did not include the posting of where the past three years survey results could be found, he stated, "I will need to get familiar with the new requirements." A facility Policy and Procedure "Examination of Survey Results" Indicated: "Policy- It is the policy of this facility that our survey reports and plans of	F 167	1. Facility has three consecutive years of survey results posted in lobby for public inspection. 2. All residents have the potential to be effected by this practice. 3. Administrator or Designee will in-service department heads and supervisors to the location and availability of the past three years of survey results. Administrator will post a sign at main entrance alerting visitors to the location of our survey results. 4. Administrator will audit the survey results randomly monthly for the next three months to ensure survey results are in the proper location. Audits will be reported in QA meeting 5. 1/13/17	

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F 167	Continued From page 2 correction be readily accessible to the patient. A listing of agencies acting as client advocates will be posted. Procedure: 1. A copy of the most recent survey report, as well as our plan of correction, will be readily accessible to all patients. 2. A notice of availability will be posted with results readily accessible to patients." The facility staff failed to have the survey results of the past three years posted for examination.	F 167		
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.	F 323		1/13/17

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F 323	Continued From page 3 (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility staff failed to provide one resident (Resident #6) in the survey sample of 22 residents an assistive device to prevent a fall. The Findings Included: Resident #6 was admitted to the facility on 9/26/12 with diagnoses of osteoarthritis, blindness both eyes, glaucoma, hypertension (high blood pressure), multiple sclerosis (MS) and dementia. Facility staff failed to provide Resident #6 with a half side rail used to assist with repositioning. A Quarterly Minimum Data Set (MDS) dated 9/16/16 assessed Resident #6 as having Severely Impaired Vision. Resident #6 had a Brief Interview for Mental Status (BIMS) score of (0) indicating severe cognitive impairment. In the area of Activities of Daily Living (ADL'S), this resident was coded as requiring total dependence of two persons physical assist in the areas of bed mobility and transfers. This resident was coded as not able to walk in room or walk in corridor. This resident was assessed as requiring total dependence of one person physical assist in the area of dressing, eating, toilet use, and personal hygiene. In the area of Range of Motion this resident was coded having Functional Limitation In Range of Motion on both sides for Upper and Lower extremities. This resident was assessed as always incontinent of Bladder and Bowel. This resident was coded as having pressure reducing	F 323	1. Resident #3 was assessed and appropriate assistive devices and fall interventions in place. 2. Residents requiring assistive devices for fall interventions have the potential to be affected by this deficient practice. Current residents with assistive devices for fall interventions have been assessed and appropriate interventions in place. 3. Nursing staff inserviced on following care plans to include the use of adaptive devices for falls by the DON or designee. 4. Unit Manager, or designee, will audit residents who use assistive devices as fall interventions 5 times a week for 3 weeks and then randomly for three months. Audits will be reported in QA meeting 5. 1/13/17	

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device for bed. In the Section Physical Restraints this area was not coded for bed rails.

A Care Plan revised 6/16/16 indicated: Focus- Risk for falls related to visual deficit/blindness/glaucoma, HTN (hypertension), memory impairments. poor decision making skills, MS and Dementia. Goal- No falls related injuries through next review. Interventions Assist with all mobility as needed, Fall risk assessment per routine and PRN (as needed). Mechanical Lift per routine.
Focus-impaired vision related to blindness, Glaucoma; Goal- Resident will have no injuries and feel safe & secure in environment through next review. Interventions- Monitor residents safety needs.
Focus- Self Care deficit requiring assist for ADL'S R/T (related to) Dementia, MS, Impaired Mobility, Visual Impairment- blindness/glaucoma, B&B (bladder/bowel) incontinence. Goal- Will have ADL's met daily Interventions- Transfer with assist of 1-2 using total lift.
Turning/repositioning/bed mobility with assist of 1-2.

A Quarterly Side Rail Assessment dated 9/15/16 indicated it was a quarterly assessment. In the area identified as who is requesting the use of side rail (s)? It was noted blank.
In the area why is the use of side rail(s) being considered? It was noted blank.
In the Section Identify all that contribute to the resident's need to use side rail(s) Physical, Cognitive, and Security, it was noted blank.
In the Section Will the side rail (s) assist the resident in bed Mobility, Transfer and Other, it was noted blank.
In the Section Additional Considerations

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Continence - Bladder Incontinent and Bowel Incontinent were coded. Toileting was coded as being Dependent. Medications that require safety measures (diuretics, psychotropic, orthostatic medications were coded No.
In the area Fluctuations in consciousness were coded No.
Decline in cognitive status was coded No.
Delirium was coded No.
In the area Will the side rail(s) impede resident's freedom of movement was coded Yes.
Will the side rail (s) obstruct the resident's view was coded Yes.
In the Section Recommendations was blank.
In the Section Further evaluation is required by, was blank.
In the Section Type was blank.
In the area Side rail precautions have been discussed with Family/Responsible party was coded Yes.
In the area Alternative to side rails have been discussed with Family/Responsible party was coded Yes.
In the area Notes Physician's orders have been obtained, including medical symptom/condition was blank.
In the area Care Plan updated was blank.

An Incident Report dated 10/25/16 indicated: Resident #6 had a fall from his bed.
A Progress Note dated 10/26/16 indicated: Type: Plan of Care- Fall committee meeting held with IDT (interdisciplinary team), and fall prevention is nursing to increase visual checks on resident, ensure bilateral side rails up and bed in lowest position.

A Physician's Progress Note dated 10/26/16 indicated: Diagnosis and assessment: Fall at

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nursing home.

Plan: Recent fall out of bed. Status post emergency room evaluation with no new intervention. Continue with safety monitoring. History of Multiple Sclerosis. Continue with medication management and full supportive care for mobility, resident with multiple muscle spasms and generalized weakness. Continue with medication management, supportive care.

Resident #6 was observed up and dressed during the survey.

A written employee statement dated 10/26/16 indicated: "At approx 6:30 P.M. on 10/25/16 I was feeding Resident #6 his supper. At around 6:55 P.M. I left his room and starting (sic) picking up trays in resident's rooms. At around 7:45 the supervisor came to find me and she stated that Resident #6 was on the floor and also stated that I left his side rail down. I went back to his room and changed his brief & clothes, and took his vitals and then the ambulance came. When she told me I left his side rail down, I did recall that I forgot to put it back up after feeding him. I want to apologize for not putting his siderail up. I won't forget again."

A Facility Reported Incident, dated 10/25/16, Indicated: Resident #6 daughter states male Certified Nursing Assistant (CNA) did not put up hand rail on fathers bed causing him to roll out of bed. Daughter believes this was done on purpose. Employee suspended pending investigation.

A follow-up investigation dated 10/28/16

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indicated: " An investigation was completed with the resident and staff members with a result of CNA admitting to forgetting to replace the handrail after assisting with Resident #6's meal but no intent to harm the resident was found."

During an interview on 12/14/16 at 3;15 P.M. with the Unit Supervisor she stated, the CNA had been reassigned and all staff had In-service training on making sure Residents with siderails were assisted after care and rails were up.

During an interview with the Administrator on 12/15/16 at 1:00 P.M. with the administrator he stated, the air mattress assisted him in rolling out of the bed. When asked to produce the manufactory guidelines on the use of the mattress, he stated, there was no other information forth coming.

A Facility Policy of Side Rails indicated: Policy: The facility in every effort to ensure the safe use of side rails as resident mobility aids and to prohibit the use of side rails as restraints to treat a resident's medical condition has developed these guidelines.

Procedure: A referral will be made to therapy to assist with the determination side rail usage.
C. 1. Bed mobility;
D. The use of side rails as an assistive device will be addressed in the resident care plan.

During an interview on 12/15/16 at 10:00 A.M. with the Physical Therapy Director, he stated nursing does the assessment for residents use of side rails.

The facility staff failed to provide Resident #6 with

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F 323	Continued From page 8 an assistive device to prevent a fall.	F 323		
F 425 SS=D	PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH CFR(s): 483.45(a)(b)(1) (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on general observations, staff interviews and facility documentation, the facility staff failed to dispose of medication in a safe manner. A blister package of 22 Calcium Carbonate tablets were disposed of in one of three small trash barrels located outside near three large trash receptacles. The findings include: On 12/13/16 at approximately 3:30 p.m., during general observations and kitchen inspection of the facility with the Food Service Manager (FSM) present, the large lid covered trash receptacles were inspected. Three other smaller trash cans were observed in the same proximity. The FSM stated the kitchen staff never placed anything in the smaller trash cans and she thought they were never used for anything. When the lid was	F 425	1. Calcium carbonate found during survey was disposed of properly by RN. 2. All residents have the potential to be affected by this deficient practice Medication carts/medication rooms will be audited for any expired or discontinued medications and dispose of appropriately as needed. 3. Director of Nursing, or designee, will in-service licensed nursing staff on the proper procedure for disposal of expired and/or discontinued medications. 4. DON, or designee, will conduct weekly audits on medication carts/medication rooms for any discontinued or expired medications for 3 months. Audits will be reported in QA meeting 5. 1/13/17	1/13/17

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removed from one of them, a blister package of unidentified white tablets were observed in the trash can. The resident's name portion had been pulled off, thus unable to identify to whom the medication was allocated for.

On 12/13/16 at 5:05 p.m., the Administrator, Unit One Nurse Manager and Corporate Nurse had retrieved the blister package from the trash can and identified the medication to be 22 *Calcium Carbonate tablets. They stated the three barrels were slated to be removed a while ago and were not actively being used. All three stated the medication was disposed of improperly, but they would never know who threw them in the general trash.

*Calcium carbonate is a dietary supplement used when the amount of calcium taken in the diet is not enough. Calcium is needed by the body for healthy bones, muscles, nervous system, and heart (https://medlineplus.gov/druginfo/meds/a601032.html).

On 12/15/16 at 12:40 p.m., during a pre-exit meeting, no further information was provided prior to survey exit.

The facility's policy and procedure titled "Disposal/Destruction of Expired or Discontinued Medications" dated 1/1/13 indicated the following: "The facility should place all discontinued or outdated medications in a designated, secure location which is solely for discontinued medication marked to identify the medications are discontinued and subject to destruction. The facility should destroy non-controlled medications in the presence of a registered nurse and

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F 425	Continued From page 10 witnessed by one other staff member, in accordance with facility policy and applicable law. The medication would be placed in a plastic bag or plastic container and add a substance that renders the medication unusable. Or, the medication can be placed in a labeled box with strong tape, 'Medication For Destruction' to be picked up by pharmacy or a licensed waste disposal company".	F 425		
F 514 SS=D	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.70(i)(1)(5) (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening	F 514		1/13/17

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F 514	Continued From page 11 and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations during a medication pass, clinical record review, staff interviews and facility documentation, the facility staff failed to ensure clinical records were accurate for 1 of 22 residents (Resident #16) in the survey sample. The facility staff failed to accurately transcribe and clarify insulin orders on the Medication Administration Record (MAR) for Resident #16. The findings include: Resident #16 was admitted to the nursing facility on 7/9/14 with diagnoses that included, but not limited to type II *Diabetes Mellitus. *Diabetes is a complex disorder of carbohydrates, fat, and protein metabolism that is primarily a result off a deficiency or complete lack of insulin secretion (Mosby's Dictionary of Medicine, Nursing & Health Professions 7th Edition). Resident #16's Admission Minimum Data Set (MDS) assessment dated 10/6/16 coded the resident with a score of 12 out of a possible total score of 15 which indicated the resident was cognitively intact with no problems in decision making. The resident was coded with a diagnosis of diabetes and required insulin injections daily.	F 514	1. Resident # 16 had orders reviewed and verified and correct medications in place. 2. All residents with medication orders have the potential to be affected by this deficient practice. Audit of current residents receiving insulin have been audited for correct order and medication. 3. Director of Nursing/ designee will in-service licensed nursing staff on medication administration to include the right dosage/right medication. 4. DON, or designee, will audit new medication orders 5 times a week for accuracy and medication availability for 3 months. Audits will be reported in QA meeting 5. 1/13/17	

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Some of the approaches the staff would implement to accomplish this goal included administration of insulin per physician orders.

The care plan for Resident #16 identified Diabetes Mellitus as a focus area that required daily insulin, as well as sliding scale insulin. The goal set by the staff for the resident was that the resident would be free on complications of diabetes and free of the signs and symptoms of hypo/hyperglycemia.

On 12/14/16 at 10:30 a.m., during a medication pass observation, Licensed Practical Nurse (LPN) #3 drew up 8 Units of Humalog insulin, stopped and stated, "Something is wrong, the MAR says Novolog 8 units not Humalog. I need to check and inform the Unit Manager." The LPN searched for Novolog in medication cart drawers, in refrigerator, Stat box as well as and other medication carts. Novolog insulin was not located and the LPN did not administer the insulin. LPN #3 said the resident needed to have her insulin one hour before lunch and dinner (4:30 p.m.) and she was scheduled to have her lunch meal at 11:30 a.m.

A one time order was obtained from the Nurse Practitioner (NP) on 12/14/16 to administer the Humalog 8 units until the Novolog insulin came in from the pharmacy. LPN #3 administered Humalog at 11:00 a.m. and delayed the lunch meal until 12:00 p.m.

Review of the MAR indicated there was a physician's order change from Humalog to Novolog on 12/8/16. The licensed nurses had been signing administration of routine Novolog from 12/8/16 through 12/13/16 at 4:30 p.m., and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 12/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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for sliding scale coverage, 10 times for Accucheck readings 201 and greater.

On 12/14/16 at 12:10 p.m., an interview was conducted with the Acting Director of Nursing. She stated the Humalog 100 units/milliliters (ml) was refilled and sent to the nursing facility on 12/6/16. The change in the order for Novolog was written on 12/7/16. She stated she expected the nurse's to have obtained the Novolog per the physician's order, but would investigate and return with more information.

An interview was conducted with the Nurse Practitioner on 12/14/16 at 1:45 p.m. She stated the facility started with a new pharmacy in November 2016 and for many residents, certain medications were not being covered for payment by their insurance. She said she may have signed a form regarding denial of coverage for the Humalog, but the pharmacy and nursing would have to retrieve the form. The NP stated both Novolog and Humalog had the same actions as a short acting insulin, it was only manufactured by a different company.

According to an interview with the Corporate Nurse on 12/15/16 at 12:15 p.m., she presented the Pharmacy form dated 12/7/16 that indicated an urgent matter regarding Humalog would no longer be covered by the resident's insurance and Novolog would be the replacement insulin. The Corporate Nurse stated the nurses would finish out the Humalog insulin since it had been recently refilled and then start the Novolog. She said, "The MAR should have reflected a clarification that Novolog would start after completion of the Humalog supply, which was the current bottle in use. The clarification should have been inherent

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in the order and nurses should have caught the documentation issue the first time they signed off for Novolog they did not have. We are glad (LPN #3's name) caught this during the medication pass and corrected the MAR."

On 12/15/16 at 12:40 p.m., the Administrator was made aware of the aforementioned issue, along with review of the same with the Acting Director of Nursing and Corporate Nurse. No further information was provided prior to survey exit.

The facility's policy and procedure titled "Documentation" dated 10/2015 indicated the following: "The Charge Nurse shall transcribe and review all physician orders in order to effect their implementation." The facility's policy titled Documentation/24 hour order review dated November 2015 indicated the following: "The night charge nurse will check new orders written in the past 24 hours. The nurse will verify the order has been transcribed correctly on the Medication Administration Record, the Treatment Record. the resident care card, and/or the calendar, as appropriate."